TE OF CALIFORNIA—HEALTH AND WELFARE AGENCY
GEORGE DEUKMEJIAN, Governor
EPARTMENT OF HEALTH SERVICES
/744 P STREET
MENTO, CA 95814

August 28, 1985

To: All County Welfare Directors
County Administrative Officers

Letter No. 85-60

LYNCH V. RANK RETROACTIVE CLAIMING PROCESS

Reference: ACWD Letter 85-52

This letter is to describe the remainder of the process that is to be used when determining retroactive eligibility and reimbursement pursuant to the Lynch v. Rank court order. The initial stages of this process were described in All County Welfare Directors Letter 85-52.

After Pickle eligibility has been determined, the county welfare department (CWD) must send the applicant the Retroactive Benefits Cover Letter (DHS 7052) (Attachment 1) and the appropriate Notice of Action (NOA). If the claimant met a SOC in any month of Pickle eligibility the CWD must send the Response Form (DHS 7053) (Attachment 2). If the applicant had months of eligibility when he/she did not meet a share of cost also send a Claim Form (DHS 7039) (Attachment 3). Applicants have sixty (60) days from the date of mailing to return the Claim Form and/or Response Form to the CWD.

Notice of Action 4 (DHS 7049) (Attachment 4) is to be used when approving an application for some or all months, or denying for other months and when the applicant met his/her share of cost during all of the retroactive months of eligibility. A completed Response Form must be sent with this notice.

Notice of Action 5 (DHS 7050) (Attachment 5) is to be sent to an applicant who is eligible during some or all months, or ineligible during other months and who did not meet a share of cost during any of the eligible months. A Claim Form must be sent with NOA 5 (complete Part I and first line of Part II. Do not send a Response Form).

Notice of Action 6 (DHS 7051) (Attachment 6) is to be used when an applicant met his/her share of cost during some months and not during other months and who may also denied for some months. A completed Response Form listing the total amount of the applicant's share of cost during the months he/she was both eligible and met a share of cost plus a completed Claim Form must be sent with Notice 6.

Each applicant who is denied either wholly or in part, must be sent an NOA that fully explains each reason for the denial for each month. In the case of a couple, only one notice is to be sent. This notice should separately identify the months of eligibility/ineligibility for each spouse. If one spouse has entered a long-term care facility the eligibility of each must be calculated as a couple during the time they lived together and separate NOAs must be sent.

NOTE: At this point, anyone who has been determined eligible for retroactive reimbursement shall be referred to as a claimant.

If a claimant states that he/she has met a share of cost in any eligible month, the CWD is responsible for verifying the amount of the share of cost and that the share of cost was actually met. Verification shall be accomplished through use of the Lynch v. Rank Share of Cost listing or by reviewing the claimant's Medi-Cal case record if the claimant's name and share of cost information is either not on the listing or the CWD has cause to believe that the amount on the listing is inaccurate.

The Share of Cost Listing is arranged by Social Security Number and contains the claimant's name and the months (between April 1980 and April 1985) in which he/she met a share of cost and the amount of that share of cost. For each eligible month the CWD will note the share of cost amount and enter the total on the Response Form and, if appropriate, on NOA 4 or 6.

After verifying the share of cost amount for each of the eligible months, the total amount must be entered on the Response Form (DHS 7053). The claimant must be provided the opportunity of accepting that amount as payment in full or returning the Claim Form requesting additional reimbursement. If he/she met the share of cost in all months of eligibility no Claim Form is to be sent.

If the Claim Form is returned incomplete the CWD is responsible for assisting the claimant in completing the Claim Form and obtaining any necessary verification. The claimants shall be allowed forty-five (45) days from the date that the CWD received the form to obtain all additional information and verification necessary to complete the form.

If a claimant has not returned his/her Claim Form or Response Form within sixty (60) days, the CWD shall make a personal contact to offer assistance in completing the form. If, during the personal contact, the CWD becomes aware that the claimant

wishes to file either the Response Form or the Claim Form, the CWD shall extend the period for returning the form for thirty (30) days.

Completed Claim Forms and Response Forms must be sent by the CWD to Kristi Banion, Department of Health Services, 714 P Street, Room 1692, Sacramento, CA 95814. If a claimant fails to return either a Claim Form or a Response Form the CWD must send a copy of the Response Form that was sent to the claimant to the above address and reimbursement will be limited to the amount of the share of cost actually met.

Required Verification

In order to obtain reimbursement for medical expenditures incurred in months other than those in which they met their share of cost, claimants shall be required to furnish verification of medical costs incurred. Acceptable verification may include:

1. Copies of receipts or bills from the provider, showing the beneficiary name, the nature of the treatment, service, or item provided, and the date of treatment or service; or

2. Cancelled checks reflecting payment to the provider, and a statement from the claimant itemizing the medical care received and the date(s) of service; or

3. A signed statement from the provider, indicating the date(s) of service, the nature of the care received, the total amount of the bill, and the amount, if any, paid by a third party.

The CWD shall determine whether the claimant has submitted necessary verification of incurred medical expenditures, prior to forwarding the Claim Forms to DHS. If further verification is needed, the CWD must provide assistance in obtaining that verification. If the provider of medical services is either unable or unwilling to provide the required information and the claimant has no cancelled check for the services the CWD should contact DHS for assistance.

Reimbursement

The amount of the reimbursement will be the amount actually paid by the claimant for Medi-Cal covered services that were provided in any month, during the retroactive period, when the claimant was Pickle eligible.

When a claimant submits an unpaid bill for a service provided during a month in which he/she was determined Pickle eligible, the CWD must provide the claimant with a letter (Attachment 7) containing a Medi-Cal card for the month that the service was provided and a letter to the provider (Attachment 8) explaining the billing procedure. If a claimant has an unpaid medical bill from a collection agency, evidence to that effect shall be submitted to DHS along with the Claim Form.

Retroactive payments made pursuant to the Lynch v. Rank court order shall not be considered as either income or resources for six months following the month they are received. During this period retroactive payments are also not subject to transfer of assets regulations. If these funds are retained, by the claimant, beyond the sixth month they will be considered as resources and could affect the claimant's eligibility for continuing Pickle or Medically Needy Medi-Cal benefits.

If the CWD is notified that either an applicant or claimant is deceased, reasonable efforts should be made to contact the administrator or executor of the estate of the deceased. This may include reviewing the case record to determine if there is a name and address of a relative to whom the notice can be sent. If a name and address is available the CWD must send a copy of the notice and follow the application process outlined in ACWD Letter 85-52.

In the case of a deceased claimant, payment will be made to the executor or administrator of the claimant's estate or to the next of kin.

Court Reports

The court has ordered DHS to provide two future monitoring reports. The requirements of the first report were outlined in ACWD Letter 85-52. The second report, due to DHS no later than June 21, 1986 must contain the following:

1. The number of Response Forms submitted to the CWD.

2. The number of Claim Forms submitted to the CWD;

3. The number of claims wholly denied, broken down by the following categories:

    a. No reimbursable medical expenses;

    b. Lack of necessary verification concerning types or dates of service, drugs, etc. provided to patient;

c. Claim Form filed untimely;

d. Insufficient proof of amount paid;

e. Failure to provide sufficient information (other than (b), (c) or (d));

4. The number of claims still pending.

For applications or claims denied for more than one reason, the court reports must indicate each reason. If there are denied applications or claims which do not fall into any of the categories listed above, the reports shall so state, and for each such application or claim shall state the reason for the denial. Mail these reports to:

Kristi Banion,
DHS - Eligibility Branch,
714 P Street, Room 1692,
Sacramento, CA 95814

Miscellaneous

1. All forms, instructions and other written materials pertaining to the Lynch v. Rank application and claims processing have been agreed upon by all of the parties involved in this lawsuit and are not subject to change without DHS obtaining the agreement of plaintiff's counsel.

2. The retro flow chart and flip chart that were provided to each CWD were for informational purposes only. The specific process to be followed when determining eligibility for retroactive reimbursement is court-ordered and is contained in this letter and in ACWD Letter 85-52.

3. The Pickle County Contact person for San Mateo County has been changed to Mary Martin, San Mateo County DSS, 255 37th Avenue, San Mateo, CA 94403, (415) 573-2740.

4. The correct address for the Riverside County Contact person is: Riverside County DPSS, 1111 Spruce Street, Riverside, CA 92587.

5. Out of state residents who met the residency requirements of Title 22, CAC, Section 50320 during the retroactive period must be sent the Application for Retroactive Reimbursement (DHS 7038). This application is to be processed the same as if the applicant was still residing in California except

that he/she would be ineligible for reimbursement during any month that the requirements of Section 50320 were not met. Attached (Attachment 9) is a declaration to be used to obtain an applicant's sworn statement that he/she met the residency requirements during all of the months of financial eligibility. This declaration is to be completed and sent to an applicant after the CWD determines that he/she is otherwise eligible for retroactive reimbursement.

6. Please note that Part III E. of the DHS 7042 Lynch v. Rank Monitoring System) omitted reference to NOA 5 which also accompanies a claim form.

7. NOA 6, is to be used only for claimants who met a SOC in some months but not in all months of Pickle eligibility.

8. Tear off "county use only" instructions prior to sending NOAs.

9. The November 8, 1983 and February 6, 1984 Lynch v. Rank Listings of Beneficiaries Notified should be used to verify the last date of receipt of SSI/SSP of any retro applicant whose name appears on one of the lists. The CA 810 and the SSA 1610 are not required for retro applicants.

10. The TPQY process may be used to verify the last date of elgibility for SSI/SSP for individuals having been discontinued less than one year. The payment history line provides the actual benefits paid to a recipient regardless of his/her payment status. The date of last SSI/SSP eligibility can be determined by comparing payment history with payment status effective date. (Payment status alone is not reliable, as it could indicate a denial rather than a termination.)

11. The 1985 Title II Disregard Computation Chart is to be used to determine a retro applicant's previous years Title II benefit amount. This is accomplished by multiplying the current benefit amount by the multiplier for the time period the last SSI/SSP check was received and subtracting the result from the current benefit amount.

12. Additional Pickle training, in the form of workshops, is being scheduled during August and September. All training will be held from 10 a.m. to 4 p.m. at Department of Health Services, 714 P Street, Conference Room 1540, Sacramento, CA 95814. The dates are August 19, 23, 30; and September 12, 16 and 23. In addition, DHS will provide two training sessions in Southern California. Dates, times and locations are forthcoming. Each workshop is limited to a maximum of 10-15

participants (two or three per county) and arrangements to attend can be made by calling Kristi Banion at (916) 324-4961 (ATSS) 454-4961.

13. Attached (Attachment 10) is the 1983 Resource Chart that was inadvertently excluded from ACWD Letter 85-52.

14. Part A line 5 of the DHS 7055 should be completed with the total number of DHS 7038 (Application for Retroactive Benefits) actually processed by the CWD in the previous month. It should not reflect the number of denials sent.

15. Some applicants may have moved since their SSI/SSP benefits were discontinued and as a result their July 1, notice was mailed to an incorrect address. In these instances the CWD must allow the applicant forty-five (45) days from the date he/she actually received the notice to apply.

Any questions regarding Lynch v. Rank or the retro process should be directed to Kristi Banion (916) 324-4961 (ATSS) 454-4961.

Sincerely,

Original signed by

Doris Z. Soderberg, Chief
Medi-Cal Eligibility Branch

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Attachments

Expiration Date: December 30, 1986

Attachment 1

Date: _____

Applicant Name: _____

Applicant SSN: _____

Worker Name: _____

Worker Phone No.: _____

: have processed your application for retroactive benefits under the court decision in *Lynch* v. *Rank*.

: have found that you were eligible for Medi-Cal under the Pickle Amendment for some months since April 1980. e State may pay you back for medical bills which you had during those months.

Enclosed you will find a Notice of Action telling you what months you were eligible for Medi-Cal under the Pickle Amendment.

The notice *also* tells you what months you were *not* eligible under the Pickle Amendment.

You can only be reimbursed for medical expenses which you had during the months when you were Pickle eligible.

Enclosed you will find a Response Form telling you how much the State owes you for those months when you were both Pickle eligible and met a share of cost. You are entitled to reimbursement in this amount once you sign and return the Response Form. (You will not receive this form if you *never* paid a share of cost.)

Enclosed you will find a Claim Form which you can use to claim reimbursement for medical expenses you had in months when you did *not* meet a share of cost. (You will not receive this form is you met a share of cost in every month when you were Pickle eligible.)

/ou have any questions or need help completing the Response Form or Claim Form, contact this Department at the ove phone number.

u may not agree with the county's decisions explained in the encosed Notice of Action. If you do not agree, you request a hearing. The notice tells you how to do that.

IETHER OR NOT YOU AGREE, COMPLETE AND RETURN A CLAIM FORM AND/OR A RESPONSE FORM MEDIATELY. THE FORM MUST BE POSTMARKED BY_____.

turn the form to: _____

_____

_____

Lynch v. *Rank* (Pickle Amendment)

RESPONSE FORM

Claimant Name: _____

Claimant ID No.: _____

Worker Name: _____

Worker Phone No.: _____

☐ I (we) will accept $_____ as full reimbursement for the share of cost that I had during the month(s) listed on page 3 of the Notice of Action. (I understand that I can request a hearing if I think the county has made a mistake.)

Important: To receive payment, you must check one box and sign below (check only *one* box):

☐ I (we) declare under penalty of perjury that I (we) paid all medical bills used to meet my (our) share of cost.

☐ I (we) declare under penalty of perjury that I (we) paid some but not all of my (our) medical bills used to meet my (our) share of cost. I (we) paid bills in the amount of $_____ .

_____ _____
Your Signature Date

_____ _____
Your Spouse's (if any) Signature Date

Return immediately to: _____

_____

_____

_____

Date: _____

Applicant Name: _____

Applicant SSN: _____

Worker Name: _____

Worker Phone No.: _____

ave processed your application for retroactive benefits under the court decision in *Lynch* v. *Rank*.

ave found that you were eligible for Medi-Cal under the Pickle Amendment for some months since April 1980. State may pay you back for medical bills which you had during those months.

Enclosed you will find a Notice of Action telling you what months you were eligible for Medi-Cal under the Pickle Amendment.

The notice *also* tells you what months you were *not* eligible under the Pickle Amendment.

You can only be reimbursed for medical expenses which you had during the months when you were Pickle eligible.

Enclosed you will find a Response Form telling you how much the State owes you for those months when you were both Pickle eligible and met a share of cost. You are entitled to reimbursement in this amount once you sign and return the Response Form. (You will not receive this form if you *never* paid a share of cost.)

Enclosed you will find a Claim Form which you can use to claim reimbursement for medical expenses you had in months when you did *not* meet a share of cost. (You will not receive this form is you met a share of cost in every month when you were Pickle eligible.)

ou have any questions or need help completing the Response Form or Claim Form, contact this Department at the e phone number.

may not agree with the county's decisions explained in the encosed Notice of Action. If you do not agree, you request a hearing. The notice tells you how to do that.

ETHER OR NOT YOU AGREE, COMPLETE AND RETURN A CLAIM FORM AND/OR A RESPONSE FORM IEDIATELY. THE FORM MUST BE POSTMARKED BY_____.

urn the form to: _____

_____

_____

Lynch v. *Rank* (Pickle Amendment)

RESPONSE FORM

Claimant Name: _____

Claimant ID No.: _____

Worker Name: _____

Worker Phone No.: _____

☐ I (we) will accept $_____ as full reimbursement for the share of cost that I had during the month(s) listed on page 3 of the Notice of Action. (I understand that I can request a hearing if I think the county has made a mistake.)

Important: To receive payment, you must check one box and sign below (check only *one* box):

☐ I (we) declare under penalty of perjury that I (we) paid all medical bills used to meet my (our) share of cost.

☐ I (we) declare under penalty of perjury that I (we) paid some but not all of my (our) medical bills used to meet my (our) share of cost. I (we) paid bills in the amount of $_____ .

_____ _____
Your Signature Date

_____ _____
Your Spouse's (if any) Signature Date

Return immediately to: _____

_____

_____

_____

Department of Health Services

CLAIM FOR REIMBURSEMENT (LYNCH v. RANK)

County Code	County Dist.	County Use

...T I — Completed by CWD

ne of mant/beneficiary _____

ial Security Number _____

dress _____

/State/Zip _____

Phone ( ) Area Code

THIS FORM MUST BE POSTMARKED BY _____

Person acting in behalf of claimant _____

Address _____

City/State Zip _____

Day Phone ( ) Area Code

Relationship to claimant _____

RT II — Completed by Beneficiary

DICAL EXPENSES FOR MONTH(S) OF _____ ONLY.

ent Name	Date of Service Mo. Day Yr.	Type of Service	Total Bill Amount	Amount Paid by Patient	Amount Paid by Other Source	Amount Owed by Patient	STATE USE ONLY
vider Name							
vider Address							
ent Name							
vider Name							
vider Address							
ent Name							
ler Name							
der Address							
			Total				
			$	$	$	$	

T III — Completed by Beneficiary

u have been contacted by a collection agency concerning any unpaid medical bill, for each bill, give the following information:

Bills	Name and Address of Collection Agency	Name of Patient	Name of Provider	Amount of Bill

erstand that if I submit unpaid medical bills, Medi-Cal may furnish me with documentation that allows my doctor or hospital to bill Medi-Cal.

by certify under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

_____

ure of claimant or person acting in claimant's behalf

_____ Date

FORM MUST BE POSTMARKED BY _____.

STATE USE ONLY

ceived _____ Date Notice of claim disposition sent: _____ Total reimbursement $ _____

ate check _____ Initials _____

by _____ Initials _____ Authorizing Signature

039 (5/85)

	Date of Service Mo. Day Yr.	Type of Service	Total Bill Amount	Amount Paid By Patient	Amount Paid By Other Source	Amount Owed By Patient	STATE USE ONLY
ent Name							
r Name							
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			Total $	$	$	$	

NOTICE OF ACTION – No. 4

Lynch v. *Rank*
Approval/Denial (Share Of Cost Met All Months)

Date: _____
Claimant Name: _____
Claimant ID No.: _____
Worker Name: _____
Worker Phone No.: _____

☐ Your application for retroactive Medi-Cal coverage under the court's decision in *Lynch* v. *Rank* has been approved for the month(s) listed on page 3. You met a share of cost in these months in the total amount of $_____. You are entitled to reimbursement in this amount once you return the completed Response Form. Sign and date the enclosed Response Form and return it to:

(County Contact)
_____
_____
_____
_____
_____
_____

☐ Your application for retroactive Medi-Cal coverage under the court's decision in *Lynch* v. *Rank* has been denied for the month(s) listed on page 4.

This action does not affect your application for current and continuing Medi-Cal. If you have any questions about this action or if there are additional facts relating to your circumstances which you have not reported to us, please write or telephone. We will answer your questions or make an appointment to see you.

The above action is in accordance with the *Lynch* v. *Rank* court decision.

If you disagree and want to appeal this decision, you may request a state hearing by following the instructions on the back of this notice. You must request a hearing within 90 days of the date of this notice.

WHETHER OR NOT YOU AGREE, RETURN THE RESPONSE FORM. THE RESPONSE FORM MUST BE POSTMARKED NO LATER THAN _____ TO BE CONSIDERED.
60 Days Hence

YOUR RIGHT TO APPEAL THIS ACTION

ı are dissatisfied with the action described on the other side, or ıther county action, you may request a state hearing before a ng Officer of the State Department of Social Services. This ıg will be conducted in an informal manner to assure that one present is able to speak freely. Your county worker can you request a hearing. If you decide to request a hearing, you do so **WITHIN 90 DAYS OF THE DATE OF THIS NOTICE.**

te hearing and aid paid pending described below will not be ble if the only action you object to is an automatic change in eligibility which is required by state or federal law. This denial tate hearing is required by Title 22, C.A.C. Section 50951.

aid Pending

ı are now receiving Medi-Cal and ask for a state hearing before fective date of this notice, you will delay the county's action, our Medi-Cal will continue until the hearing begins.

Regulations Available

regulations, including those covering state hearings, are avail- the local office of the county welfare department.

rized Representative

an represent yourself at the state hearing. You can also be rep- ed by a friend, attorney or any other person, but you are ed to arrange for the representative yourself. You can get help ating free legal assistance by calling the toll-free number of Inquiry and Response Unit 1-800-952-5253.* For the deaf DD: 1-800-952-8349.*

Information Practices Act Notice

The information you are asked to write in below is needed to process your request, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the record for decision and may locate this record by contacting Public Inquiry and Response Unit (phone number shown above). Any information you provide may be shared with the county welfare department, with the U.S. Department of Health and Human Services. Authority: W&IC 14100.2.

How to Request a State Hearing

The best way to request a hearing is to contact your nearest county welfare department. That address is on the other side of this form.

You may also request a hearing by calling the toll-free number of Public Inquiry and Response Unit.* They can provide you with further information about your hearing rights or files. Assistance is also available in some languages other than English, including Spanish. You may phone, write, or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

EST FOR A STATE HEARING

_____
Phone Number

_____
Address City State Zip Code

_____

uesting a state hearing because of an action by the welfare department of _____ county related to Medi-Cal. for my request:

_____

_____

_____

language other than English and need an interpreter for my hearing. (The State will provide the interpreter at no cost to you.)

_____
Dialect

NOTICE OF ACTION – No. 4 (Continued)

Lynch v. *Rank* (Pickle Amendment)

Claimant Name: ____________________

Claimant ID No.: ____________________

Worker Name: ____________________

Worker Phone No.: ____________________

ITEMIZED STATEMENT – APPROVAL(S) (SHARE OF COST MET)

Month	Year	Amount	Month	Year	Amount	Month	Year	Amount
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______

NOTICE OF ACTION – No. 4 (Continued)

Lynch v. *Rank* (Pickle Amendment)

Claimant Name: _____
Claimant ID No.: _____
Worker Name: _____
Worker Phone No.: _____

ITEMIZED STATEMENT – DENIAL(S)

Month	Year	Reason:
_____	198__	_____
_____	198__	_____
_____	198__	_____
_____	198__	_____
_____	198__	_____
_____	198__	_____
_____	198__	_____
_____	198__	_____
_____	198__	_____
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_____	198__	_____
_____	198__	_____
_____	198__	_____
_____	198__	_____

FOR COUNTY USE ONLY

Lynch v. *Rank* (Pickle Amendment)

Approval/Denial (Share of Cost Met All Months)

County Instructions for Pickle NOA No. 4 — WAS ON MEDI-CAL, MET SHARE OF COST

Use with NOA No. 4

Itemized Statement — Approval(s) (Share of Cost Met)

Itemized Statement — Denial(s)

Response Form

(1) Person(s) has/have been determined Pickle eligible for the *entire* retroactive period.

Send: NOA No. 4 (check approval box)

Itemized Statement — Approval(s) (Share of Cost Met)

Response Form

(2) Person(s) has/have been determined eligible for a *portion* and denied for a *portion* of the retroactive period. Person(s) paid share of cost in all months of eligibility.

Send: NOA No. 4 (check approval *and* denial boxes)

Itemized Statement — Approval(s) (Share of Cost Met)

Itemized Statement — Denial(s)

Response Form

NOTICE OF ACTION – No. 5

Lynch v. *Rank*
Retroactive Eligibility
Approval/Denial (No Share Of Cost Met)

Date: _____
Claimant Name: _____
Claimant ID No.: _____
Worker Name: _____
Worker Phone No.: _____

☐ Your application for retroactive Medi-Cal coverage under the court's decision in *Lynch* v. *Rank* has been approved for the month(s) listed on page 3.

You may be paid back for medical expenses which you had during those months. To receive reimbursement for the month(s) you have been approved, you must complete the enclosed claim form. Send in the claim form, with verification of all medical expenses for which you are claiming reimbursement. Return claim form to:

(County Contact)
_____
_____
_____
_____
_____
_____

THE CLAIM FORM MUST BE POSTMARKED NO LATER THAN _____ IN ORDER TO BE CONSIDERED.

☐ Your application for retroactive Medi-Cal coverage under the court's decision in *Lynch* v. *Rank* has been denied for the month(s) listed on page 4.

This action does not affect your application for current and continuing Medi-Cal. If you have any questions about this section or if there are additional facts relating to your circumstances which you have not reported to us, please write or telephone. We will answer your questions or make an appointment to see you in person.

The above action is in accordance with the *Lynch* v. *Rank* court decision.

If you disagree and want to appeal this decision, you may request a state hearing by following the instructions on the back of this notice. You must request a hearing within 90 days of the date of this notice.

WHETHER OR NOT YOU AGREE, YOU SHOULD RETURN THE CLAIM FORM.

YOUR RIGHT TO APPEAL THIS ACTION

ı are dissatisfied with the action described on the other side, or ıther county action, you may request a state hearing before a ng Officer of the State Department of Social Services. This ıg will be conducted in an informal manner to assure that one present is able to speak freely. Your county worker can you request a hearing. If you decide to request a hearing, you do so WITHIN 90 DAYS OF THE DATE OF THIS NOTICE.

te hearing and aid paid pending described below will not be ble if the only action you object to is an automatic change in eligibility which is required by state or federal law. This denial tate hearing is required by Title 22, C.A.C. Section 50951.

aid Pending

ı are now receiving Medi-Cal and ask for a state hearing before fective date of this notice, you will delay the county's action, our Medi-Cal will continue until the hearing begins.

Regulations Available

regulations, including those covering state hearings, are avail- the local office of the county welfare department.

ırized Representative

an represent yourself at the state hearing. You can also be rep- ed by a friend, attorney or any other person, but you are ted to arrange for the representative yourself. You can get help ating free legal assistance by calling the toll-free number of Inquiry and Response Unit 1-800-952-5253.* For the deaf DD: 1-800-952-8349.*

Information Practices Act Notice

The information you are asked to write in below is needed to process your request, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the record for decision and may locate this record by contacting Public Inquiry and Response Unit (phone number shown above). Any information you provide may be shared with the county welfare department, with the U.S. Department of Health and Human Services. Authority: W&IC 14100.2.

How to Request a State Hearing

The best way to request a hearing is to contact your nearest county welfare department. That address is on the other side of this form.

You may also request a hearing by calling the toll-free number of Public Inquiry and Response Unit.* They can provide you with further information about your hearing rights or files. Assistance is also available in some languages other than English, including Spanish. You may phone, write, or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

EST FOR A STATE HEARING

Phone Number

Address City State Zip Code

uesting a state hearing because of an action by the welfare department of _____ county related to Medi-Cal.
for my request:

a language other than English and need an interpreter for my hearing. (The State will provide the interpreter at no cost to you.)

ge Dialect

NOTICE OF ACTION — No. 5 (Continued)

Lynch v. *Rank* (Pickle Amendment)

Claimant Name: ____________________
Claimant ID No.: ____________________
Worker Name: ____________________
Worker Phone No.: ____________________

ITEMIZED STATEMENT — APPROVAL(S) (SHARE OF COST NOT MET)

Month	Year	Month	Year	Month	Year
_______	198__	_______	198__	_______	198__
_______	198__	_______	198__	_______	198__
_______	198__	_______	198__	_______	198__
_______	198__	_______	198__	_______	198__
_______	198__	_______	198__	_______	198__
_______	198__	_______	198__	_______	198__
_______	198__	_______	198__	_______	198__
_______	198__	_______	198__	_______	198__
_______	198__	_______	198__	_______	198__
_______	198__	_______	198__	_______	198__
_______	198__	_______	198__	_______	198__
_______	198__	_______	198__	_______	198__
_______	198__	_______	198__	_______	198__
_______	198__	_______	198__	_______	198__
_______	198__	_______	198__	_______	198__
_______	198__	_______	198__	_______	198__
_______	198__	_______	198__	_______	198__
_______	198__	_______	198__	_______	198__
_______	198__	_______	198__	_______	198__

NOTICE OF ACTION – No. 5 (Continued)

Lynch v. *Rank* (Pickle Amendment)

Claimant Name: ____________________
Claimant ID No.: ____________________
Worker Name: ____________________
Worker Phone No.: ____________________

ITEMIZED STATEMENT – DENIAL(S)

Month	Year	Reason:
______	198__	______________________________
______	198__	______________________________
______	198__	______________________________
______	198__	______________________________
______	198__	______________________________
______	198__	______________________________
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______	198__	______________________________
______	198__	______________________________
______	198__	______________________________
______	198__	______________________________

NOTICE OF ACTION – No. 5 (Continued)

FOR COUNTY USE ONLY

Lynch v. *Rank* (Pickle Amendment)
Approval/Denial (No Share Of Cost Met)

County Instructions for Pickle NOA No. 5 – DID NOT MEET SHARE OF COST AND/OR NOT ON MEDI-CAL DURING ANY MONTH OF PICKLE ELIGIBILITY

Use with NOA No. 5

Itemized Statement – Approval(s) (Share of Cost *Not* Met)

Itemized Statement – Denial(s)

Claim for Reimbursement

(1) Person(s) has/have been determined Pickle eligible for the *entire* retroactive period but never met share of cost.

Send: NOA No. 5

Itemized Statement – Approval(s) (Share of Cost Not Met)

Claim for Reimbursement

(2) Person(s) has/have been determined eligible for a *portion* but never met a share of cost and denied for a *portion* of the retroactive period.

Send: NOA No. 3

Itemized Statement – Approval(s) (Share of Cost Not Met)

Itemized Statement – Denial(s)

Claim for Reimbursement

OTICE OF ACTION – No. 6

Lynch v. *Rank*
SHARE OF COST MET/NOT MET/DENIED)

Date: _____
Claimant Name: _____
Claimant ID No.: _____
Worker Name: _____
Worker Phone No.: _____

] Your application for retroactive Medi-Cal coverage under the court's decision in *Lynch* v. *Rank* has been approved for the month(s) listed on page 3. You met a share of cost in these months in the total amount of $_____. You are entitled to reimbursement in this amount once you return the completed Response Form. Sign and date the enclosed Response Form and return it to the person named below.

] You were also eligible for Medi-Cal under the Pickle Amendment in the months listed on page 4. However, you did not meet a share of cost in those months. If you want to receive reimbursement for medical bills you had during those months, you must complete both the enclosed Claim Form. Submit the Claim Form with verification of *all* medical expenses for which you are claiming reimbursement. Send the completed form(s) to:

(County Contact)

_____
_____
_____
_____
_____
_____
_____

] Your application for retroactive Medi-Cal coverage under the court's decision in *Lynch* v. *Rank* has been denied for the month(s) listed on page 5. Refer to page 5 for an explanation.

his action does not affect your application for current and/or continuing Medi-Cal. If you have any questions bout this notice or if there are additional facts you wish to have considered, please write or telephone. We will nswer your questions or make an appointment to see you in person.

ne above action is in accordance with the *Lynch* v. *Rank* court decision.

you disagree and want to appeal this decision, you may request a state hearing by following the instructions on e back of this notice. You must request a hearing within 90 days of the date of this notice.

HETHER OR NOT YOU AGREE, SEND THE COMPLETED FORMS TO THE COUNTY CONTACT ABOVE. HE RESPONSE FORM AND CLAIM FORM (IF APPLICABLE) MUST BE POSTMARKED NO LATER THAN _____ TO BE CONSIDERED.
60 Days Hence

YOUR RIGHT TO APPEAL THIS ACTION

you are dissatisfied with the action described on the other side, or ıy other county action, you may request a state hearing before a earing Officer of the State Department of Social Services. This earing will be conducted in an informal manner to assure that veryone present is able to speak freely. Your county worker can elp you request a hearing. If you decide to request a hearing, you ıust do so **WITHIN 90 DAYS OF THE DATE OF THIS NOTICE.**

state hearing and aid paid pending described below will not be ailable if the only action you object to is an automatic change in our eligibility which is required by state or federal law. This denial a state hearing is required by Title 22, C.A.C. Section 50951.

id Paid Pending

you are now receiving Medi-Cal and ask for a state hearing before e effective date of this notice, you will delay the county's action, us your Medi-Cal will continue until the hearing begins.

ate Regulations Available

ate regulations, including those covering state hearings, are avail- at the local office of the county welfare department.

ıthorized Representative

ou can represent yourself at the state hearing. You can also be rep- ented by a friend, attorney or any other person, but you are pected to arrange for the representative yourself. You can get help locating free legal assistance by calling the toll-free number of blic Inquiry and Response Unit 1-800-952-5253.* For the deaf ly TDD: 1-800-952-8349.*

Information Practices Act Notice

The information you are asked to write in below is needed to process your request, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the record for decision and may locate this record by contacting Public Inquiry and Response Unit (phone number shown above). Any information you provide may be shared with the county welfare department, with the U.S. Department of Health and Human Services. Authority: W&IC 14100.2.

How to Request a State Hearing

The best way to request a hearing is to contact your nearest county welfare department. That address is on the other side of this form.

You may also request a hearing by calling the toll-free number of Public Inquiry and Response Unit.* They can provide you with further information about your hearing rights or files. Assistance is also available in some languages other than English, including Spanish. You may phone, write, or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

QUEST FOR A STATE HEARING

e _____ Phone Number

_____

Address City State Zip Code

_____

requesting a state hearing because of an action by the welfare department of _____ county related to Medi-Cal.
ons for my request:

_____

_____

_____

ak a language other than English and need an interpreter for my hearing. (The State will provide the interpreter at no cost to you.)

uage _____ Dialect _____

NOTICE OF ACTION — No. 6 (Continued)

Lynch v. *Rank* (Pickle Amendment)

Claimant Name: ____________
Claimant ID No.: ____________
Worker Name: ____________
Worker Phone No.: ____________

ITEMIZED STATEMENT — APPROVAL(S)
(SHARE OF COST MET)

Month	Year	Amount	Month	Year	Amount	Month	Year	Amount
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______
______	198__	$______	______	198__	$______	______	198__	$______

Lynch v. *Rank* (Pickle Amendment)

Claimant Name: ______________________
Claimant ID No.: ______________________
Worker Name: ______________________
Worker Phone No.: ______________________

ITEMIZED STATEMENT – APPROVAL(S)
(SHARE OF COST NOT MET)

Month	Year	Month	Year	Month	Year
______	198__	______	198__	______	198__
______	198__	______	198__	______	198__
______	198__	______	198__	______	198__
______	198__	______	198__	______	198__
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______	198__	______	198__	______	198__
______	198__	______	198__	______	198__
______	198__	______	198__	______	198__
______	198__	______	198__	______	198__

NOTICE OF ACTION – No. 6 (Continued)

Lynch v. *Rank* (Pickle Amendment)

Claimant Name: _____
Claimant ID No.: _____
Worker Name: _____
Worker Phone No.: _____

ITEMIZED STATEMENT – DENIAL(S)

Month	Year	Reason:
_____	198__	_____
_____	198__	_____
_____	198__	_____
_____	198__	_____
_____	198__	_____
_____	198__	_____
_____	198__	_____
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_____	198__	_____
_____	198__	_____
_____	198__	_____
_____	198__	_____
_____	198__	_____
_____	198__	_____

FOR COUNTY USE ONLY

Lynch v. *Rank* (Pickle Amendment)

County Instructions for Pickle NOA No. 6 – MET SHARE OF COST (SOME MONTHS) AND/OR DID NOT MEET SHARE OF COST (SOME MONTHS)

Use with NOA No. 6

Itemized Statement – Approval(s) (Share of Cost Met)

Itemized Statement – Denial(s)

Response Form

Itemized Statement – Approval(s) (Share of Cost Not Met)

Claim for Reimbursement

(1) Person(s) has(have) been determined Pickle eligible for the *entire* retroactive period. Met Share of Cost for a *portion* of this period *and* did *not meet* Share of Cost for a *portion* of this period.

Send: NOA No. 6

Itemized Statement – Approval(s) (Share of Cost Met)

Response Form

Itemized Statement – Approval(s) (Share of Cost Not Met)

Claim for Reimbursement

(2) Person(s) has(have) been determined eligible (with Share of Cost met and/or Share of Cost not met) for a *portion* of the retroactive period and denied for a *portion* of the retroactive period.

Send: NOA No. 6

Itemized Statement – Approval(s) (Share of Cost Met)

Response Form

Itemized Statement – Approval(s) (Share of Cost Not Met)

Claim for Reimbursement

Itemized Statement – Denial(s)

DATE: _____
BENEFICIARY NAME: _____
WORKER NAME: _____
WORKER PHONE: _____

Dear _____:

Attached is your prior-month Medi-Cal card for the month(s) of _____. This card(s) was issued in accordance with the Lynch v. Rank Court Decision.

Also attached is a letter to your doctor or other medical provider, granting permission to bill more than one year after the date of service. Please give your provider that letter, along with your Medi-Cal identification label for the month of service, so that is may be attached to the completed bill. The Medi-Cal program cannot pay your provider's bill unless a copy of that letter is submitted with the bill and your Medi-Cal label for the month of service.

If you have any questions, please call the eligibility worker listed above.

Sincerely,

_____ County Welfare Office

attachment

Dear Medical Provider:

Attached is a Medi-Cal identification label for _____ for the month of _____. This label was issued in accordance with the Lynch v. Rank court decision.

A copy of this letter, along with the patient's Medi-Cal label, must be attached to your completed claim form for the month of service. The completed claim form should then be submitted to the fiscal intermediary at the following address:

Department of Health Services
Operations Unit
Fiscal Intermediary
Management Branch
714 P Street, Room #950
Sacramento, CA 95814

Redwood Health
3033 Cleveland Avenue
Santa Rosa, CA 95401
(Sonoma, Mendocino, Lake Counties ONLY)

Please note that the fiscal intermediary will not honor a claim submitted more than one year after the date of service unless a copy of this letter is attached to the claim. To ensure that these claims will be processed, code the billing limit box on the claim form with an "8", mark the attachment box on the claim with an "X" and indicate the date proof of eligibility was received in the remarks section of the claim. (See Provider Manual, Section 2-8b.)

Should you have any questions regarding this matter, please contact the _____ _____ _____.
County Department (area code) Telephone Number

Sincerely,

_____
Medi-Cal Program Manager

DECLARATION -- OUT-OF-CALIFORNIA APPLICANT

The undersigned declares:

1. I have filed an Application for Retroactive Reimbursement (Lynch v. Rank) in order to receive retroactive Medi-Cal benefits from the State of California.

2. To the best of my knowledge, all of the information I provided to the State of California in my Application for Retroactive Reimbursement (Lynch v. Rank) is true and correct.

3. During each month for which I am seeking retroactive Medi-Cal benefits from the State of California, I was a resident of California, and I did not leave the state for more than 60 days at any one time. My California residence was at _____ (street number)

_____
(street) (city) (county)

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated: _____

_____
SIGN NAME

_____
PRINT NAME

_____
PRINT ADDRESS

_____
PHONE NUMBER

TREATMENT OF RESOURCES
PICKLE ELIGIBILITY DETERMINATION
1983

Resource Limits: 1 Person = $1,500
2 Persons = $2,250

Persons must be within resource limit at 12:01 a.m. on the first day of the month

RESOURCE	TREATMENT	REQUIRED VERIFICATION
Home Property (Principal Residence)	The dwelling plus any appertaining buildings and land used as a home by the applicant/beneficiary and his/her spouse or the parents with whom an eligible child is living does not count as a resource.1/ PR remains exempt so long as the applicant/beneficiary intends to return home. 2/ Only one PR may be exempt at any time.	None if applicant/beneficiary resides in P If questionable that land appertains to PR verify with tax statement, assessor's offi deed, title, etc.
Life Estate	Counted unless PR. Value determined by Life Estate and Remainder Interest Tables. If power to dispose of property is retained or life estate is revocable use CMV.	View life estate document.
Mineral Rights	Excluded if equity value is $6,000 or less and is producing a net annual return of six percent of excludable equity value or if they can't be sold.	Tax assessed value from brokerage firm, holding company, etc.
Property (Real or Personal) Essential to Self-Support	Excluded if <u>all</u> of the following criteria are met: 1. Used in a trade or business or is otherwise producing income; and 2. Equity value does not exceed $6000; and 3. The activity is producing a net annual return of 6% of the excludable equity value. Property that can't be sold, at any price, has no CMV.	Knowledgeable source estimate i.e., real estate appraisers, banks, mortgage compani savings and loans to determine value. Income tax return; Schedule C, E, F or SE, Form 1065 to determine net annual return.

1. If applicant/beneficiary ,spouse, minor child, <u>or</u> dependent relative continues to reside in principal residence.
2. Regardless of reason for absence, an applicant/beneficiary must provide a statement of his/her intent to return to liv in the prinicpal residence.

RESOURCE	TREATMENT	REQUIRED VERIFICATION
Contract of Sale, Notes, Mortgages, Trust Deeds, and Loans	Counted, if negotiable. Amount of outstanding principal balance or the discounted amount.	View document(s). Negotiability and value must be verified by a bank, real estate broker, or other financial institution.
Automobile NOTE: RV's are not considered automobiles. RV's are included in Personal Effects.	One auto totally excluded if used by the individual or a member of the individual's household: for employment, is necessary to obtain regular medical treatment, or is modified for operation by a handicapped person. If no automobile is excluded above, $4500 of the CMV may be excluded. Any amount in excess of $4500 must be included as a non-liquid resource. A second vehicle may be excluded if needed for self support or to maintain daily activities and one vehicle is not sufficient to do so. (See Definitions) Where an applicant (and/or spouse) is engaged in an income producing activity and an additional vehicle is necessary to conduct business, that vehicle must be evaluated as Property Essential to Self-Support.	Determine value vehicle license fee chart (VLF) substituting 1983 for current year. Applicant's/beneficiary's signed statement regarding use of automobile(s) for: - regular medical treatment - employment - modified for operation by a handicapped person.
Recreational Items and Vehicles (boats, campers motor homes, trailers etc.)	Consider as household (HH) goods and personal effects, unless used as principal residence.	Applicant's/beneficiary's signed statement and records.

RESOURCE	TREATMENT	REQUIRED VERIFICATION
Household Goods and Personal Effects	Includes but is not limited to: Furnishings, furniture, appliances, clothing, jewelry. Exclude wedding and engagement rings. Total equity value of (HH) goods and personal effects may not exceed $2,000. Note: It is presumed that the value of HH goods and effects is at least $1,000.	Applicant's/beneficiary's signed statement and records.
Items of Unusual Value (See Definitions)	Deduct any legal debts against the property.	Copy of contract or signed statement from no holder to verify legal debts.
Musical Instruments	Excluded if CNV per item is under $500. Counted as HH goods and personal effects	Applicant's/beneficiary's signed statement and records.
Cash, Checking, Savings, Credit Union Accounts	Counted. If applicant or responsible relative has unrestricted access to the funds in a joint checking account, all of the funds in the account are presumed to be the resources of the applicant. This presumption may be rebutted.	Applicant's/beneficiary's statement if total countable resources are $1,000 or less and n more than $500 of that amount is a liquid resource. Otherwise, copy of bank statement savings account book, etc.
Stocks, Bonds, Mutual Funds	Counted. Use the closing price on the date eligibility determination is being completed.	Obtain copy of stock certificate or a state-ment of account from securities firm.
United States Savings Bonds	Counted on the earliest date that it can be cashed.	Table of Redemption Values for U. S. Savings Bonds or value from bank or savings and loan institution.

RESOURCE	TREATMENT	REQUIRED VERIFICATION
Keogh, IRA, Pension Accounts Time Deposits	Counted. Deduct penalty for early withdrawal. If verified that funds cannot under any circumstances be withdrawn, the funds are excluded until maturity.	Examine time deposit certificate or statement from financial institution.
Loans Which Require Repayment	Counted, if funds are retained more than 30 days from date of receipt.	Copy of loan documents.
Nonrecurring Lump Sum	Counted. SSI/SSP and RSDI retroactive payments are excluded for six months following the month of receipt.	Applicant's/beneficiary's signed statement.
Replacement of Lost, Stolen, Destroyed, or Damaged Property	Excluded for nine months from date of receipt. An additional nine month extension may be granted for circumstances beyond applicant's/beneficiary's control.	Copy of written evidence showing the source, amount, date and intended purpose. If written evidence is unavailable, use applicant's/beneficiary's statement under penalty of perjury.
Income Tax Refund	Counted, if retained for more than 90 days.	Copy of tax return.
Proceeds of a Life Insurance Policy and Other Death Benefits	Exclude if applicant/beneficiary is both the beneficiary and the owner of the policy and the CSV of the policy has previously been excluded as a resource. Count if applicant/beneficiary is both the beneficiary and the owner of the policy and the CSV of the policy has not previously been excluded as a resource. Note: If applicant/beneficiary is not the owner of the policy, the proceeds are treated as unearned income.	View policy or verification from insurance company.

RESOURCE	TREATMENT	REQUIRED VERIFICATION
-ust Funds [ncludes Court Ordered -usts)	Excluded if access to principal is restricted (e.g., only the trustee or court, etc. has access) even if providing income. Interest is counted as unearned income unless it is reinvested in the trust	Review trust document. Petitioning the cour to break the trust is not required.
ɹrial Insurance	Excluded. If policy has CSV, count the same as life insurance.	View policy or verification from insurance company.
ife Insurance	Exclude if total face value (FV) of all insurance policies on any person do not exceed $1,500 (do not count term insurance). If total FV is over $1,500, count <u>all</u> cash surrender value (CSV) of <u>all</u> policies.	View policy or verification from insurance company.
ɹrial Funds see Definitions)		
Burial Trusts (see Definitions)	Exclude up to $1800 if irrevocable	Applicant's/beneficiary's statement and copy of trust agreement.
Burial Contracts (see Definitions)	Exclude up to $1800 if irrevocable.	Applicant's/beneficiary's statement and copy of contract.

RESOURCE	TREATMENT	REQUIRED VERIFICATION
Separately Identifiable Funds for Burial	Exclude up to $1500. If funds are commingled with other resources the burial fund exclusion does not apply. If funds are used for another purpose, the amount used must be counted as a liquid resource in the month following the month in which the funds were expended. NOTE: $1500 limit is reduced by the amount(s) applicant/beneficiary has in: - face value of life insurance if CSV is excluded. and/or - amount of any irrevocable burial trust/ contract etc. that would cause the total burial funds to exceed the $1800 maximum.	Existing or Newly Acquired Accounts: The funds must be clearly designated as set aside for burial. If not designated on account, but are separately identifiable an applicant/beneficiary states funds are intended for burial, obtain signed statemen Funds may be excluded the first day of the month in which statement is signed, if desi nation on account is completed within 30 da of the statement.
Burial Plots/Spaces (see Definitions)	Excluded if for immediate family member.	Applicant's/beneficiary's statement.
Livestock and Poultry	Exempt if for personal use.	Applicant's/beneficiary's statement.
Major Disaster Assistance	If excluded from income, these funds are also excluded nine months from date of receipt. Possible nine months extension.	Must not be commingled with other resources. If person is applicant, allow 30 days to establish separately identifiable account fo these funds. Accept applicant's/beneficiary's statement re: source of funds.
Alaskan Natives Stock in Regional or Village Corporations	Excluded until January 1, 1992.	View documents.